U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 19 September 2007

Case No. 2005-BLA-5897

In the Matter of:
C.R.[1], widow of E.R.
Claimant,

v.

BETHENERGY MINES, INC.,
Employer
and
BETHLEHEM STEEL CORP.,
C/O ACORDIA EMPLOYERS SERVICE,
Carrier
and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

BEFORE: THOMAS F. PHALEN, JR.
Administrative Law Judge

DECISION AND ORDER – DENIAL OF BENEFITS

[1] Effective August 1, 1006, the Department of Labor directed the Office of Administrative Law Judges, the Benefits Review Board, and the Employee Compensation Appeals Board to cease use of the name of the claimant and claimant family members in any document appearing on a Department of Labor web site and to insert initials of such claimant/parties in the place of those proper names. In support of this policy change, DOL has adopted a rule change to 20 C.F.R. Section 725.477, eliminating a requirement that the names of the parties be included in decisions. Further, to avoid unwanted publicity of those claimants on the web, the Department has installed software that prevents entry of the claimant's full name on final decisions and related orders. This change contravenes the plain language of 5 U.S.C. 552(a)(2) (which requires the internet publication), where it states that "in ***each case*** the justification for the deletion [of identification] shall be explained fully in writing." (*emphasis added*). The language of this statute clearly prohibits a "catch all" requirement from the OALJ that identities be withheld. Even if §725.477(b) gives leeway for the OALJ to no longer publish the names of Claimants – 5 U.S.C. 552(a)(2) clearly requires that the deletion of names be made on a case by case basis.

I also strongly object to this policy change for reasons stated by several United States Courts of Appeal prohibiting such anonymous designations in discrimination legal actions, such as *Doe v. Frank*, 951 F. 2d 320 (11th Cir. 1992) and those collected at 27 Fed. Proc., L. Ed. Section 62:102 (Thomson/West July 2005). This change in policy rebukes the long standing legal requirement that a party's name be anonymous only in "*exceptional cases*." *See Doe v. Stegall*, 653 F.2d 180, 185 (5th Cir. 1981), *James v. Jacobson*, 6 F.3d 233, 238 (4th Cir. 1993), *and Frank* 951 F.2d at 323 (noting that party anonymity should be rarely granted)(*emphasis added*). As the Eleventh Circuited noted, "[t]he ultimate test for permitting a plaintiff to proceed anonymously is whether the plaintiff has a substantial privacy right which outweighs the customary and constitutionally-embedded presumption of openness in judicial proceedings." *Frank*, 951 F.2d at 323.

This is a decision and order arising out of a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901-962, ("the Act") and the regulations thereunder, located in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.[2]

On May 18, 2005, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs, for a hearing. (DX 31).[3] A hearing was held on this matter on July 26, 2006 in Hazard, Kentucky. (Tr. 1). At the hearing, both parties submitted evidence, but chose to call no witnesses.

On September 22, 2006, Jackson Kelly was granted a motion to withdraw as Employer's counsel in this matter. (ALJX 2). I then issued an order on May 29, 2007 allowing parties to submit briefs past the deadline – given that Employer may wish to hire new counsel. (ALJX 3). The deadline has long since passed, and I failed to hear from either party. As was indicated in my order, I shall take this silence as acquiescence to moving forward on the record. *See Id.* All parties were afforded the opportunity to call and to examine and cross examine witnesses, and to present evidence, as provided in the Act and the above referenced regulations.

ISSUES[4]

The issues in this case are:

1. Whether Claimant is an eligible survivor;

2. Whether Claimant was dependent upon Miner;

Finally, I strongly object to the specific direction by the DOL that Administrative Law Judges have a "mind-set" to use the complainant/parties' initials if the document will appear on the DOL's website, for the reason, *inter alia*, that this is not a mere procedural change, but is a "substantive" procedural change, reflecting centuries of judicial policy development regarding the designation of those determined to be proper parties in legal proceedings. Such determinations are nowhere better acknowledged than in the judge's decision and order stating the names of those parties, whether the final order appears on any web site or not. Most importantly, I find that directing Administrative Law Judges to develop such an initial "mind-set" constitutes an unwarranted interference in the judicial discretion proclaimed in 20 C.F. R. § 725.455(b), not merely that presently contained in 20 C.F.R. § 725.477 to state such party names.

[2] The Department of Labor amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001, and are found at 65 Fed. Reg. 80, 045-80,107 (2000)(to be codified at 20 C.F.R. Parts 718, 722, 725 and 726). On August 9, 2001, the United States District Court for the District of Columbia issued a Memorandum and Order upholding the validity of the new regulations. All citations to the regulations, unless otherwise noted, refer to the amended regulations.

[3] In this Decision, "DX" refers to the Director's Exhibits, "EX" refers to the Employer's Exhibits, "CX" refers to the Claimant's Exhibits, "Tr." to the transcript of the hearing, and "ALJX" as the Administrative Law Judge Exhibits.

[4] At the hearing, Employer withdrew the following issues: timeliness, miner, post 1969 employment, responsible operator, insurance, subsequent claim, and cumulative employment of one year. (Tr. 17-18). Employer also stipulated to thirty-two years of coal mine employment. (Tr. 17). Employer stated that it would withdraw the issues of dependency and survivor upon Claimant submitting a statement signed to the effect that she did not remarry after E.R.'s death and that she is the only dependent. (Tr. 16). Claimant's counsel failed to submit the signed statement. Therefore, dependency and survivor still remain at issue.

3. Whether the Miner has pneumoconiosis as defined by the Act;

4. Whether the Miner's pneumoconiosis arose out of coal mine employment; and

5. Whether the Miner's death was due to pneumoconiosis.

(DX 31; Tr. 16-18).

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

E.R. ("Miner") was born on March 16, 1928 and passed away on August 1, 2002 at the age of 74 years. (DX 1, 13; CX 7). A marriage certificate shows he married C.R. on January 20, 1984. (DX 12). There is no evidence in the record that they either divorced, that C.R. ("Claimant") has remarried, or that anyone other than Claimant was dependent on Miner at the time of death. In her application for benefits, Claimant marked that she was a surviving spouse of the Miner. (DX 2; CX 7).[5] She also marked that they did not have any dependent children or disabled children. *Id.* Based upon her application and lack of contrary evidence, I find that Claimant is an eligible surviving spouse of Miner and his only dependent.

Procedural History

Miner filed his initial claim on June 27, 1973 and was denied on October 30, 1979. (DX 1). Miner then filed a duplicate claim on July 27, 1983, which was denied by the deputy commissioner on January 10, 1984 and subsequently referred to the Office of Administrative Law Judges for a formal hearing. The administrative law judge made no ruling as to whether Miner established a material change in condition, but reviewed the second claim pursuant to the provisions of 20 C.F.R. Part 718. The administrative law judge awarded benefits on August 27, 1987. (DX 1-32). This finding was affirmed by the Benefits Review Board ("Board") on July 27, 1989. (DX 1-7).

C.R. filed a claim for survivor's benefits on April 5, 2004. (DX 2). On January 28, 2005, the District Director, OWCP, issued a proposed decision and order – denial of benefits. (DX 26). Claimant timely requested a formal hearing. (DX 28). On May 18, 2005, this claim was transferred to the Office of Administrative Law Judges for a formal hearing. (DX 31).

At the hearing in Hazard, Kentucky on July 26, 2006, both parties were represented by counsel. (Tr. 1). No witnesses were called. On September 22, 2006 – I granted Jackson Kelly's

[5] Claimant also checked that Miner had never been married to anyone else. (DX 3). In fact, the evidence establishes that Miner married S.W. on June 8, 1949, but that they divorced on November 9, 1983. (CX 7).

motion to withdraw as Employer's counsel in this matter. (ALJX 2). I then issued an order on May 29, 2007 allowing parties to submit briefs past the deadline – given that Employer may wish to hire new counsel – and requested that notice be given if new counsel was desired. (ALJX 3). I indicated that absence of a response from the parties would indicate a desire to proceed on the record. *Id*. Neither Employer nor Claimant's counsel responded.

Length of Coal Mine Employment

The Social Security Earnings records and the other evidence of record establishes, and I find, that Miner was a coal miner within the meaning of § 402(d) of the Act and § 725.202 of the regulations. The District Director found that Miner engaged in thirty-three years of coal mine employment, from October 1, 1950 to June 30, 1984. (DX 26). This is the same length of coal mine employment found by previous adjudicators. Employer has stipulated to thirty-two years, and I so find the record supports such a stipulation. As such, Miner is credited with thirty-two years of coal mine employment.

Dependency

The evidence shows E.R. marred C.R. on January 20, 1984. (DX 12). There is nothing in the record that indicates Miner had other dependents at the time of his death. No evidence has been submitted to contradict the fact Miner was not married to Claimant, that Claimant did not live with Miner at the time of his death, or that she has remarried. Therefore, I find Miner has one dependant for purposes of augmentation under § 725.205.

MEDICAL EVIDENCE

Section 718.101(b) requires any clinical test or examination to be in substantial compliance with the applicable standard in order to constitute evidence of the fact for which it is proffered. *See* §§ 718.102 - 718.107. The claimant and responsible operator are entitled to submit, in support of their affirmative cases, no more than two chest x-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two blood gas studies, no more than one report of each biopsy, and no more than two medical reports. §§ 725.414(a)(2)(i) and (3)(i). Any chest x-ray interpretations, pulmonary function studies, blood gas studies, biopsy report, and physician's opinions that appear in a medical report must each be admissible under § 725.414(a)(2)(i) and (3)(i) or § 725.414(a)(4). §§ 725.414(a)(2)(i) and (3)(i). Each party shall also be entitled to submit, in rebuttal of the case presented by the opposing party, no more than one physician's interpretation of each chest x-ray, pulmonary function test, arterial blood gas study, or biopsy submitted, as appropriate, under paragraphs (a)(2)(i), (a)(3)(i), or (a)(3)(iii). §§ 725.414(a)(2)(ii), (a)(3)(ii), and (a)(3)(iii). Notwithstanding the limitations of §§ 725.414(a)(2) or (a)(3), any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease, may be received into evidence. § 725.414(a)(4). The results of the complete pulmonary examination shall not be counted as evidence submitted by the miner under § 725.414. § 725.406(b).

Claimant submitted a Summary Evidence Form. (CX 10). Claimant submitted Drs. Marshall and Myer's x-ray readings as initial evidence. (CX 1, 2). For pulmonary function

studies, Claimant submitted those of Drs. Clarke and Nash as initial evidence. (CX 3, 4). Under ABGs, Claimant submitted Drs. Nash and Williams's studies. (CX 4, 5). The medical reports of Drs. Clarke and Nash were also submitted as initial evidence. (CX 3, 4). In terms of hospitalization records and treatment notes, Claimant submitted the death certificate (DX 13; CX 7), medical records dated March 9, 1999 through May 30, 2002 from Dr. Tholpady (DX 21; CX 8) and medical records dated May 29, 1991 through July 13, 2002 from Drs. Tholpady and Foster. (DX 20; CX 9). Claimant's evidence complies with the requisite quality standards of §§ 718.102-107 and the limitations of § 725.414 (a)(3). Therefore, I admit the evidence as designated in Claimant's summary form for purposes of compliance with § 725.414.

Employer submitted an Amended Summary Evidence form on August 10, 2006. (EX 7). As initial evidence, Employer designed the x-rays of Drs. Wiot and Spitz (DX 24, 25), the PFT studies of Drs. Tomsky and Williams (DX 20, EX 1), the ABG of Dr. Williams (EX 1), and the medical reports of Drs. Castle and Jarboe. (EX 3, 2). Employer also submitted the depositions of Drs. Castle and Jarboe. (EX 8, 6). Under "other medical evidence," Employer has submitted the CT scan interpretations of Drs. Wiot and Spitz (DX 24, EX 4; DX 25). Employer also designated the treatment notes at DX 20-21. For rebuttal evidence, Employer submitted Dr. Castle's deposition (EX 6) for the purposes of invalidating the PFTs contained at CX 3 and CX 4. Employer's evidence complies with the requisite quality standards of §§ 718.102-107 and the limitations of § 725-414 (a)(3). The deposition testimony complies with § 725.414(c). Therefore, I admit the evidence Employer designated in its amended summary form.

X-RAYS

Exhibit	Date of X-Ray	Date of Reading	Physician/ Qualification	Film Quality	Interpretation
CX 1	???[6]	5/02/1984	Dr. Marshall[7]	1	2/2pq[8]
CX 2	4/25/1983	4/09/1984	Dr. Meyers	None Given	1/1pq[9]
DX 24	5/18/2002	9/28/2002	Dr. Wiot, B-reader,[10] BCR[11]	3	Negative; mass consistent with

[6] It is impossible to tell the date this x-ray was originally taken from the evidence before this court. § 718 Appendix A, subpart 13 require that each x-ray "shall be permanently and *legibly* marked with the name and address of the facility at which it is made, the miner's DOL claim number, the *date of the roentgenogram*, and the left and right side of the film. §718 Appendix A(13)(*emphasis added*). Here, it appears the physician interpreting the x-ray wrote by where the date belongs "not clear."

[7] Claimant asserted this physician has B-reader credentials and is board certified in radiology. However, his credentials were not submitted along with the x-ray or indicated to be anywhere else in the record. Furthermore, it is impossible to tell the signature of the physician or read the printed name of the physician – as the copy provided to this court is of such low quality. Therefore, I shall consider this physician to have no credentials.

[8] These designations are taken from Claimant's summary evidence form, as most of this x-ray interpretation is of such a quality it is unreadable. Due to the numerous deficiencies with this piece of evidence as discussed *supra*, I shall accord it no weight for determining the presence of pneumoconiosis.

[9] There is no indication this x-ray was taken for the purpose of determining pneumoconiosis – and there is no record of the film quality for this x-ray. Furthermore, there is no indication this x-ray was read in accordance with ILO classifications. *See § 718.102(b).* As a result, this x-ray is not in compliance with the quality standards of § 718.102 and Appendix A to Part 718. Therefore, I accord this x-ray interpretation no weight for purposes of determining whether Miner suffers from pneumoconiosis under § 718.202(a)(1).

[10] A "B" reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by or on behalf of the Department of Health

					malignancy
DX 25	5/18/2002	11/05/2004	Dr. Spitz, B-reader, BCR	2	Negative; carcinoma of the right lung with metastasis

PULMONARY FUNCTION TESTS

Exhibit/ Date	**Co-op./ Undst./ Tracings**	**Age/ Height**	**FEV_1**	**FVC**	**MVV**	**FEV_1/ FVC**	**Qualifying Results**	**Comments**
CX 3[12] 4/27/1983	Good Yes/Yes	55/68.75	1.60	4.10		39[13]		
CX 4 5/05/1983	Good Yes/Yes	55/70.5	.73	1.50	56	49		Claimant is considered a "non-smoker"; patient "became very dizzy during testing. Could not continue"
DX 20 5/23/2002[14]	Not noted; No	74/68	2.63	3.00		75		125 pack year smoking history; not smoked in 11 years; data is acceptable and reproducible according to Dr. Tomski
EX 1 10/19/1983	Good Yes/Yes	55/68.75	3.45	4.45	136	78%		

*Indicates post-bronchodilator values

and Human Services. This is a matter of public record at HHS National Institute for Occupational Safety and Health reviewing facility at Morgantown, West Virginia. (42 C.F.R. § 37.5l) Consequently, greater weight is given to a diagnosis by a "B" Reader. *See Blackburn v. Director, OWCP*, 2 B.L.R. 1-153 (1979).

[11] A physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. *See* 20 C.F.R. § 727.206(b)(2)(III). The qualifications of physicians are a matter of public record at the National Institute of Occupational Safety and Health reviewing facility at Morgantown, West Virginia.

[12] There appear to be only two tracings accompanying this study – not the required three under § 718 Appendix B – and the two FEV1's provided vary by more than 5%. *See § 718 Appendix B(2)(G)* requiring that the variation between the two largest FEV1's of the three acceptable tracings should not exceed 5 percent of the largest FEV1 or 100ml, whichever is greater.

[13] The physician indicated that the ratio was 17% - but this is clearly not the case. It appears he used the first FEV1 (0.70), not the greatest of the two against the FVC, to calculate the ratio.

[14] No precise date is given on the PFT report. However, it appears to have been administered during a hospital stay from May 21-23, 2002.

Employer submitted Dr. Castle's report for the purposes of rebuttal to Claimant's Pulmonary Function Tests. (EX 6). In the rebuttal Dr. Castle, who is board certified in internal medicine and in the subspecialty of pulmonary diseases, stated that the May 1983 PFT by Dr. Clarke located at CX 3 was invalid. Specifically, Dr. Castle noted "there is a pulmonary function study which is totally invalid because of less than maximum effort, hesitation at the onset of exhalation, and lack of reproducibility. Nothing, really, is seen here, other than passive exhalation … and clearly is totally inaccurate." (EX 6). Regarding Dr. Nash's PFTs located at CX 4, Dr. Castle opined that they were also invalid. He reasoned that the studies "did not represent anything other than, again, passive exhalation. They are not reproducible, they are not conducted for the appropriate time period, there is less than maximal effort, and there is hesitation at the onset of exhalation. This is a totally invalid study that does not represent his maximal effort." (EX 6). Given Dr. Castle's superior credentials, along with other deficiencies found in the PFT studies as noted *supra*, I find the PFT studies located at CX 3 and CX 4 to be invalid and accord them no weight.

ARTERIAL BLOOD GAS STUDIES

Exhibit	**Date**	**pCO_2**	**pO_2**	**Qualifying**	**Comments**
CX 4	05/05/1983	49.6	62.9		
CX 5	10/19/1983	35.3 31.7*	86.1 92.9*		Exercise was treadmill at 15pmh, 10% grade.

*indicates Post-Exercise

Narrative Reports

Dr. Clarke examined Miner/Records and submitted a medical report. (CX 3). Dr. Clarke, whose credentials are not provided, examined Miner on April 27, 1983 for a pulmonary evaluation. Miner revealed that his chief complaint was shortness of breath – something which did not occur prior to his employment as a coal miner. Dr. Clarke considered thirty-two years of coal mine employment; twenty-seven of those years were spent as a motor man driving tunnel through rock, all at the face of the mine. Five of those years were spent working at a preparation plant. Miner is last noted as working in early September of 1982. In terms of smoking history, Dr. Clarke considered a thirty pack year history – with Miner quitting seven months prior to the examination. Miner's weight was at 190 pounds.[15] The physical examination revealed bilateral inspiratory and expiratory rales and rhonchi. Dr. Clarke also noted increased AP diameter of the chest and some early clubbing of the finger tips. The objective testing was as follows: PFT (mild restrictive and severe obstructive airway disease), x-ray (2/2pq (rounded opacities) and 1/0st (irregular opacities)). Based on these tests, Dr. Clarke opined that the most likely cause of the ventilatory impairment is coal dust exposure from his previous employment. Dr. Clarke concludes by noting he was "unable to determine any other cause for his [Miner's] disabling dyspnea other than his work in a dusty environment."

Dr. Nash examined Miner/Records and submitted a medical report. (CX 4). Dr. Nash, whose credentials are not provided, examined Miner on May 5, 1983 for a pulmonary evaluation. At the time of the examination, Miner was fifty-five years of age. Dr. Nash considered a twenty-

[15] He was also noted as being five foot eight and three-quarter inches tall.

six year coal mine employment history, where Miner last worked as a motorman, rock driller and a general inside worker.[16] He noted that Miner was "cut off from his job on September 2, 1982," but officially retired on April 8, 1983. Symptoms have included shortness of breath for twenty-years and a dry cough for eight years. Miner can walk up one flight of stairs without resting and can walk one half mile on level ground without resting. Smoking history is listed as forty years at a half pack a day, quitting October 19, 1982. Physical examination revealed a respiratory rate of eighteen breaths per minute with mild dyspnea. Auscultation of the posterior chest revealed a few wheezes in the posterior bases with no rales. The objective evidence was as follows: x-ray (which was ordered by the physician personally and read by him – even though there is another physician's signature on the x-ray. It is described by Dr. Nash as showing "a moderate increase of pulmonary and vascular markings in the perihilar areas and along the cardiac borders suggestive or, and compatible with congestive failure, or chronic lung disease, or both. There is also a fair number of small radio-opaque densities measuring 5mm or less in the parenchyma of the lungs in the lower two-thirds of the x-ray" which is compatible with a finding of coal workers' pneumoconiosis. The upper third of the x-ray was completely normal), an ABG (PO2 of 62.9 and PCO2 of 49.6 – moderate amount of hypoxemia with a low PO2 and low oxygen saturation – according to Dr. Nash – this equates to a total disability by the DOL standards, which is not true), PFT (totally disabling respiratory impairment). Based on the above, Dr. Nash diagnosed the following: arteriosclerotic heart disease with myocardial ischemia, blindness in left eye, probable discogenic disease of the lumbar spine, chronic obstructive lung disease, and coal workers' pneumoconiosis stage II. Based on the above information, Dr. Nash stated that he considered Miner "totally and permanently disabled for all work, especially heavy work in a dusty environment like coal mines" and that the respiratory problems were a result of working thirty-two years in and around the coal mines.

Dr. Castle who is board certified in internal and pulmonary medicine, as well as a B-reader, conducted a medical evidence review and submitted a report dated May 22, 2006. (EX 2). He was deposed by Employer on August 7, 2006. (EX 8). In rendering his opinion, Dr. Castle considered the following: Survivor's form for benefits under the Black Lung Benefits Act dated April 3, 2004; Death Certificate noting Miner's death occurred on August 1, 2002 listing congestive heart failure due to lung cancer as the immediate cause of death; the interrogatories of Claimant dated May 28, 2004; radiographic report by Dr. Thomas Haines on an x-ray dated May 17, 2002; Medical records from Dr. Tholpady (diagnoses included hypertensive cardiovascular disease, status post coronary artery bypass surgery; hyperlipidemia; allergic rhinitis; acid peptic disease; benign prostatic hypertrophy); consultation note by Dr. Larry Foster dated June 6, 1997 (notes Miner suffered from discomfort in his left side; smoking history of 100 pack years – quitting in 1991; mining history of thirty-six years; Miner weighed 245 pounds; oxygen saturation of 96% on room air; CT and x-ray impression of small area pleural thickening of the pleura of the left upper lung zone and an ill-defined, less than 1mm nodule of the right upper lobe); operative note dated March 18, 1999; miscellaneous medical records (Miner seen for constipation and chronic dorsal pain associated with hypertrophic arthritis); history and physical from Wellmont Holston Valley Medical Center (impressions of right upper lobe lung mass; atypical chest pain; multivessel coronary artery disease; status post coronary artery bypass grafting; possible obstructive lung disease; hypertension); radiation oncology consultation dated

[16] Dr. Nash also considered six years of outside coal mine employment – where Miner worked as a railroad car cleaner, railroad car dropper, and a refuse truck driver.

May 23, 2002; letter from Dr. Keith Kramer dated May 20, 2002; outpatient medical records from Dr. David Miller (diagnosed nonsmall cell carcinoma felt to be at least state III-B [diagnosis was made by fine needle aspiration of the subcarinal mass], coronary artery disease, status post coronary artery bypass surgery); discharge summary from Wellmont Holston Valley Medical Center with date of discharge May 23, 2002 (diagnoses were lung cancer, chest pain, coronary disease, status post CABG); outpatient medical records from Dr. David Miller (Miner received combined modality therapy with radiation therapy and low-dose chemotherapy for state III B nonsmall cell lung carcinoma); discharge summary from Appalachian Regional Healthcare with date of discharge May 29, 1991 (hypertensive cardiovascular disease with acute intramural myocardial infarction, atrial fibrillation with uncontrolled heart rate resolved, excessive cigarette smoking and addiction, history of peptic duodenal ulcer, partial blindness of the eye, chronic hematuria of unknown cause, and lumbosacral disc disease); discharge summary from Norton Community Hospital dated April 4, 1999 (diagnoses were renal lithiasis, stable hypertensive cardiovascular disease, severe allergic rhinitic, morbid exogenerous obesity, coal miner accident previously with right leg fracture, status post prostate surgery, exogenous obesity and hyperlipidemia, mild underlying renal insufficiency); discharge summary from Norton Community Hospital dated May 2, 1999 (diagnoses were right ureteral stone with obstruction and hydronephrosis, renal insufficiency with azotemia, stable hypertensive cardiovascular disease, hyperlipidemia, severe allergic rhinitis, exogenous obesity); discharge summary from Norton Community Hospital dated July 16, 2002 (history of right-sided lung cancer with metastases admitted with fever, white blood cell count was at 1.8; admitted for septicemia, leucopenia, and fever; hospice care was discussed with family as Miner's condition had deteriorated to the point that death was imminent within the next six months; final diagnoses were septicemia secondary to neutropenia caused by chemotherapy for metastatic large cell lung carcinoma, and hypertensive cardiovascular disease); medical records from Wellmont Holston Valley Medical Center dated May 18, 2002 (one week history of migratory anterior chest pain radiating to the back; history of coronary artery disease and previous CABG; history of asthma is noted; diagnoses were right upper lobe lung mass, atypical chest pain, multivessel coronary artery disease, status post CABG, possible restrictive lung disease, hypertension); a pulmonary consultation note by Dr. Bruce Grover dated May 20, 2002 (which noted a history of smoking, coal mining, asthma, peptic ulcer disease, degenerative joint disease, obesity, hypertension, coronary artery disease, and coronary artery bypass grafting; impressions were right lung mass with a hilar and mediastinal adenopathy suspicious for bronchogenic carcinoma, renal insufficiency, former smoker; a hematology/oncology consultation note with an impression of multiple medical problems and at least a state III B nonsmall cell lung cancer, combined modality therapy was recommended; radiation oncology consultation note dated May 23, 2002 that noted Miner would receive combined modality therapy for his lung cancer; discharge summary dated May 23, 2002 with diagnoses of lung cancer, poorly differentiated large cell carcinoma of the lung, chest pain/improved, and coronary disease, status post CABG; CT scan report dated May 18, 2002 indicating that there was a large right lower lobe mass with extensive mediastinal lymphadenopathy; x-ray report dated May 18, 2002 showing a large right lung mass suspicious for neoplasm and mild cardiomegaly; PFT study dated May 23, 2002 (opined to be valid) with FVC of 3.00 and FEV1 of 2.25 and a ratio of 75%; cytopathology report dated May 23, 2002 indicating that a fine needle aspiration biopsy showed poorly differentiated large cell carcinoma; medical records from Holston Valley Hospital dated May 29, 1991 where Miner was admitted with chest pain (diagnoses included triple vessel coronary artery disease, status post

unstable angina pectoris, hypertension, chronic obstructive pulmonary disease, tobacco abuse, hypercholesterolemia, history of microscopic hematuria and peptic ulcer disease); CT scan dated July 5, 2002 showing a large mass representing carcinoma, in the superior segment of the right lower lobe with slight narrowing of the segmental bronchus – these were abnormal lymph nodes in the mediastinum representing metastatic disease; medical records from Norton Community Hospital dated May 17, 2002 (diagnoses were hypertensive cardiovascular disease, unstable angina, status post CABG, mild renal insufficiency, right lung mass); x-ray report by Dr. Wiot dated May 18, 2002 read as negative for pneumoconiosis; CT scan reading by Dr. Wiot dated May 19, 2002 that noted no evidence of pneumoconiosis, but found a large mass in the posterior segment of the right upper lobe with associated mediastinal and subcarinal adenopathy consistent with a large malignancy; PFT dated October 19, 1983 which he found invalid, but had a FVC of 4.45 and FEV1 of 3.45; ABG studies dated October 19, 1983 with a resting PCO2 of 35.3 and a PO2 of 86.1 and an exercise PCO2 31.7 and PO2 of 92.9.

Based on the above Dr. Castle opines Miner did not suffer from coal workers' pneumoconiosis. He credits Miner with 36.5 years in the coal mines and a 100 pack year smoking history based on the above records. He explains the various risk factors for Miner's pulmonary problems. First, he addresses coal dust exposure, along with cigarette smoking, history of asthma and allergic rhinitis, obesity, history of coronary artery bypass grafting, and lung cancer. Because Miner does not have a consistent finding of rales, crackles, or crepitations, no positive radiographic evidence of pneumoconiosis,[17] and the valid physiologic studies he considers that were done around the time of Miner's diagnosis of lung cancer (2002) did not reveal a disabling functional impairment from any cause including coal workers' pneumoconiosis, Dr. Castle opines that Miner did not suffer from either clinical or legal pneumoconiosis.[18] Furthermore, he concludes that Miner's death was not caused by, contributed to, or hastened in any way by coal workers' pneumoconiosis. Dr. Castle cites the stage III B large cell carcinoma – which resulted from tobacco abuse and the fact coal dust is not a known cause of cancer – as the cause of Miner's death. He points to the fact that the medical records show a clear decline of health in the Miner beginning with the diagnosis of lung cancer which progresses until his death. Thus, in Dr. Castle's opinion, Miner would have died at the same time and of the same condition had he never stepped foot into a mine.[19]

Dr. Castle's deposition merely restates the above opinion and reiterates his reasoning. (EX 8). However, in the second part of the examination, Dr. Castle also considered CX 2 – an x-ray report by Dr. Myers dated April 9, 1984 which was read as 1/1, positive for pneumoconiosis. Dr. Castle opined that this evidence did not change his mind, as more superior readers read subsequent x-rays to be negative. Furthermore, Dr. Castle noted subsequent CT scans were read as negative and that CT scans are more reliable than x-rays. He acknowledges that if Miner did have pneumoconiosis in 1984 – it could not have gone away. Thus – he believed it was much more likely given the above that Miner never suffered from the condition. (EX 8).

[17] He specifically cites Dr. Wiot's readings of the x-ray and CT scans – noting Dr. Wiot is "an internationally known radiologist and B-reader."

[18] He specifically cites the PFT studies dated May of 2002 which showed a 107% total lung capacity – i.e., normal results, at the time Miner was first diagnosed with cancer. According to Dr. Castle's records, this is nearly twenty years after Miner left the coal mines.

[19] Dr. Castle points out that even if Miner suffered from simple coal workers' pneumoconiosis, he still would opine that it did not contribute to his death. This opinion is based upon a lack of physiologic changes indicating disability.

Dr. Jarboe, who is board certified in internal and pulmonary medicine, as well as a B-reader, conducted a medical evidence review and submitted a report dated May 22, 2006. (EX 3). He was deposed by Employer on July 6, 2006. (EX 5). In his medical evidence review, Dr. Jarboe considered the following: survivor's form dated April 3, 2004 which indicated Miner was born on March 16, 1928 and died on August 1, 2002 with no autopsy; Death Certificate noting the principal cause of death was congestive heart failure in turn due to lung cancer – with no mention of pneumoconiosis; interrogatories completed by the Claimant; x-ray report dated May 17, 2002 with a large mass noted in the upper right lobe with a CT to follow up – x-ray was otherwise clear; page two of a history and physical by Dr. Tholpady diagnosing hypertensive cardiovascular disease, allergic rhinitis treated with desensitization injections; Dr. Foster's pulmonary consultation dated June 6, 1997 (Miner sought treatment because of an abnormal x-ray and pain in left side. Dr. Foster noted a history of emphysema and bronchitis with a 100 pack year smoking history. A history of coal workers' pneumoconiosis and mining accidents are listed along with a thirty-six year history in the mines (mostly, if not all, underground). Oxygen saturation was 96% on room air, weight was 245 pounds, breath sounds were slightly diminished but no rales or wheezes were identified, x-ray was said to show limited expansion bilaterally with an ill-defined pleural based shadow in the left upper lung zone. CT scan showed no significant adenopathy, but a very small pleural based area of thickening and a very small ill-defined nodule was noted in the right upper lung zone of unclear significant. No description of a pattern which would suggest coal workers' pneumoconiosis is provided); a page from a history and physical performed on May 18, 2002 (ABG with PCO2 of 35 and a PO2 of 81; cardiovascular diagnoses were right upper lobe mass, atypical chest pain, multivessel coronary artery disease, possible obstructive lung disease, hypertension, and allergic rhinitis; no mention of coal workers' pneumoconiosis); Miner's oncologist's notes (indicating a diagnosis of poorly differentiated large cell lung cancer and Miner was to be treated with radiation and chemotherapy – smoking history of 2.5 packs a day for fifty years); discharge summary from Holston Valley Medical Center dated May 18 – May 23, 2002 (admitted with chest pain, large mass found in right lung. Bronchoscopy revealed a lung carcinoma. Discharge summary listed lung cancer, poorly differentiated large cell, improved chest pain, coronary disease, status post coronary artery bypass surgery); discharge summary from Appalachian Regional Hospital dated May 27, May 29, 1991 (admitted with unstable angina and transferred to Holston Valley – social history noted Miner smoked heavily over last several decades – diagnoses on admission were hypertensive cardiovascular disease and history of peptic ulcer, chest x-ray is described as unremarkable while ABGs showed a "mild hypoxia," but failed to provide numbers); admission records from Appalachian Hospital dated April 4 and April 30, 1999 with admission for a renal stone (x-ray showed borderline cardiomegaly, mild COPD, and postcoronary bypass grafting; discharge summary dated April 4, 1999 lists diagnoses of stable hypertensive disease, severe allergic rhinitis, and morbid exogenous obesity); discharge summary from Norton Community Hospital dated July 13 – July 16, 2002 (Miner admitted with septicemia due to neutropenia – caused by chemotherapy – ABG showed PO2 of 58 while x-ray dated July 15, 2002 showed the right lung mass and subsegmental atelectasis distal to the mass); CT scan dated May 18, 2002 (several large lymph nodes were noted in the mediastinum and the mass was identified in the right infrahilar region; left lung described as "well expanded and clear"); PFT dated May 23, 2002 with FVC of 3.00, a FEV1 of 2.25 and a ratio of 75% - total lung capacity was 107% and a smoking history of 125 pack years is noted; Holston Valley admission and physical records dated May 29, 1991 (admitted with chest pain, history of high blood pressure, two pack a day habit for

48 years and continuing to smoke, mother died of asthma at 38 years of age, Miner diagnosed with unstable angina, long smoking history, and probable COPD; Miner underwent coronary artery bypass grafting); CT scan dated July 5, 2002 (showed a "huge mass" in the superior segment of the right lower lobe with slight narrowing of the segmental bronchus and abnormal nodes in the mediastinum – representing metastatic disease. No mention of coal workers' pneumoconiosis); notes from Dr. Tholpady – Miner's treating physician – dated March 2, 1999 through April of 2002 (weight of 250 in 1999 and "markedly obese," clear chest, and diagnosed with stable hypertensive cardiovascular disease and severe allergic rhinitis under treatment. Notes dated May 24, 2002 stated large left [Dr. Jarboe notes this is the wrong side] lung cancer. No mention of coal workers' pneumoconiosis); x-ray dated May 18, 2002 read by Dr. Wiot as showing no evidence of pneumoconiosis; CT scan dated May 19, 2002 read by Dr. Wiot as showing no evidence of pneumoconiosis; PFT and ABG dated October 19, 1983 by Dr. Williams with a FVC of 4.45, FEV1 of 3.45, and an MCC of 136; ABG at rest showed a PO2 of 86.1, increasing to 92.9 after exercise.

Based on the above review of the evidence, Dr. Jarboe opined that sufficient evidence does not exist to make a diagnosis of coal workers' pneumoconiosis. He points that there is no radiographic evidence of the disease, including multiple x-rays and CT scans. Also, he describes the physiological evidence presented above – which demonstrate a normal physiological capacity which is something you would not see in an individual with coal workers' pneumoconiosis. In determining that Miner suffered from no pulmonary impairment, Dr. Jarboe stated he estimated Miner left the coal mining industry around 1983. Dr. Jarboe cites pulmonary studies in 1983, 1997, and at the onset of cancer in May of 2002 to articulate that Miner suffered no pulmonary impairment. Regarding the July 2002 ABG with a PO2 of 58, Dr. Jarboe opined that this was most likely a result of exposure to chemotherapy and radiation.

Concerning disability, Dr. Jarboe felt that from a respiratory standpoint, Miner retained the pulmonary to perform the work of a coal miner up to the point he developed lung cancer. He cites a PO2 study which was taken while Miner was on chemotherapy and radiation as being drastically different from previous normal studies. Regarding the cause Miner's death, Dr. Jarboe stated that there is virtually no evidence that Miner had the disease of coal workers' pneumoconiosis. Furthermore, he opined that no evidence exists that Miner had any significant functional respiratory impairment up until the few weeks/months prior to his death. The impairment which did exist in the latter part of his life was due to the presence of the "huge carcinoma in the right lung and subsequent treatment with radiation and chemotherapy." Thus pneumoconiosis, in Dr. Jarboe's opinion, did not play a role in contributing to, hastening, or causing Miner's death. If he assumed that Miner suffered from pneumoconiosis, because it would be such a small amount as to not show up in the radiographic evidence he considered (x-rays and CT scans as noted above), and given the lack of ventilatory impairment or blood gas exchange, he opined that it would not be of such a level to contribute in any way to Miner's death.

Dr. Jarboe's deposition merely restates the above opinion and reiterates his reasoning. (EX 6). He specifically notes that there are no records which indicate treatment for pneumoconiosis (legal or clinical). (EX 6, p. 16).

Hospital and Treatment Records Contained at DX 20 & DX 21[20]

Appalachian Regional Healthcare

-Discharge Summary dated May 29, 1991: Presented to the hospital with sharp chest pain occurring over the last three days; it is noted he was "working very hard at remodeling his house." Just prior to admission, it is noted Miner experienced pressure-like, retrosternal chest pain radiating to both arms and his jaw accompanied with shortness of breath. It is noted he smoked very heavily for the last several decades. At rest, Miner is not short of breath. The chest is described as clear to percussion and auscultation. On admission, Miner is diagnosed with hypertensive cardiovascular disease, unstable angina pectoris, atrial fibrillation with uncontrolled heart rate. Chest x-ray is unremarkable. The ABG shows a mild hypoxia. Miner is transferred to Holston Valley Hospital on May 29, 1991.

Norton Community Hospital

-CT Scan dated May 27, 1997: 7x7mm density seen at the posterior aspect of the upper right lobe. Mild bronchiectatic changes noted in the upper lung zones. Overall impression of pleural thickening of the posterolateral aspect of the left upper lobe; 7mm density seen only on the lung window setting at the posterior aspect of the right upper lobe.

-Radiology report dated April 2, 1999: an x-ray showing mild changes of chronic obstructive lung disease.

-Discharge Summary dated April 4, 1999: Miner is hospitalized with right renal stone. History includes "hypertensive cardiovascular disease, normal sinus rhythm, interventricular conduction defect, status post coronary artery bypass graft surgery for relief of angina, hyperlipidemia, allergic rhinitis, morbid exogenous obesity, and a coal mine accident." The chest is described as clear to percussion and auscultation. Diagnoses include severe allergic rhinitis and morbid exogenous obesity. X-ray shows borderline cardiomegaly, mild changes of chronic obstructive pulmonary disease and previous changes of coronary artery bypass surgery.

-Radiology report dated May 17, 2002: large rounded mass in the posterior right upper lobe, approximately 7cm x 7.5 cm with irregular margins. Lungs otherwise clear.

-CT scan dated July 5, 2002 by Dr. Goplan: huge mass measuring 7.7cm x 5.3 cm in the posterior to the right main stem bronchus in the superior segment of the right lower lobe. There

[20] Included in the treatment notes are multiple radiology reports. There is no evidence in the record as to the x-ray reading credentials of these physicians. §718.102(c). Also, these interpretations were all related to the treatment of Miner's condition, and not for the purpose of determining the existence or extent of pneumoconiosis. In addition, there is no record of the film quality for any of these x-rays. §718.102(b). Finally, the interpreting physicians did not provide an ILO classification for their readings. §718.102(b). As a result, these x-ray interpretations are not in compliance with the quality standards of §718.102 and Appendix A to Part 718. Therefore, I accord the x-ray interpretations contained in the treatment records no weight for the purpose of determining whether Miner suffers from pneumoconiosis under § 718.202(a)(1).

Treatment records addressing non-pulmonary conditions will not be addressed.

is also subsegmental atelectasis in the left lower lung zone. The impression is that the large mass was carcinoma and the abnormal lymph nodes in the mediastinum represent metastatic disease.

-Discharge Summary dated July 13, 2002 by Dr. Tholpady: While the chest is described as clear to auscultation, Miner is noted to be short of breath with a non-productive cough. The assessment includes a fever of unknown origin, septicemia and neutropenia, acute renal insufficiency; right sided lung cancer with metastasis, thrombocytopenia, history of coronary artery disease, hypertension, and status post coronary artery bypass graft. An x-ray is noted as showing the right upper lung mass unchanged from an older x-ray.

-Radiology report dated July 15, 2002 by Dr. Haines: shows the large lung carcinoma in the right perihilar area as well as widening in the mediastinum and paratrachael region; development of atelectasis on the right; left lung is "relatively clear."

Dr. Tholpady

-Diagnosis sheet undated: hypertensive cardiovascular disease, normal sinus rhythm, status post coronary artery bypass surgery and no angina at present; hyperlipidemia under treatment with diet and oral medications; allergic rhinitis treated with desensitization injections; stable acid peptic disease; benign prostatic hypertrophy requiring surgery.

-Ambulatory Progress Notes dated March 2, 1999 – April 4, 2000: weekly notes of allergy shots. On most days, Miner receives a shot in each arm. A diagnosis note dated March 2, 1999 lists severe allergic rhinitis under treatment with injections and Allegra and morbid exogenous obesity as Miner's conditions.[21]

-Letter to Dr. Tholpady from Dr. Keith Kramer at Cardiovascular Associates dated May 20, 2002: notes Miner's x-ray shows a right upper lobe lung mass, which was confirmed by a CT scan. It is expected the mass will reveal to be a chest malignancy.

-Medical report dated July 16, 2002: lungs are described as clear.

-Discharge Summary dated July 16, 2002 from Norton Community Hospital. Final diagnoses include: septicemia secondary to neutropenia caused by chemotherapy for metastatic large cell lung carcinoma, hypertensive cardiovascular disease, hyperlipidemia, renal failure with hyperkalemia, pain secondary to cancer, history of right sided lung cancer with metastasis, and status post coronary artery bypass surgery. No mention of pneumoconiosis in past medical history. X-ray showed right upper lobe mass unchanged from his old chest x-ray. A blood gas with a PO2 of 58 and a pH of 7.3 – which Dr. Tholapdy feels shows metabolic acidosis. Prognosis is extremely poor, and if things get any worse, he will be either admitted as terminal care or be put in hospice by his family until he expires.

Wellmont Holston Valley Hospital

-Discharge Summary dated June 11, 1991 by Dr. David Sewell: the following conditions are noted: triple vessel coronary artery disease; status post unstable angina pectoris; hypertension;

[21] Other diagnoses are also made but are unrelated to a pulmonary condition.

COPD; tobacco abuse; hypercholesterolemia; history of microscopic hematuria; history of peptic ulcer disease.

-Operative Report dated June 4, 1991 by Dr. Sewell: Miner underwent coronary artery bypass graft surgery times three, using saphenous vein to the distal right coronary artery, to the second marginal branch of the circumflex and using a left internal mammary artery to the distal third of the left anterior descending.

-History and Physical dated May 18, 2002: ABG reveals PCO2 of 35, and a PO2 of 81. Impression is that Miner has a right upper lobe lung mass, atypical chest pain, coronary artery disease, possible obstructive lung disease, hypertension, allergic rhinitis, and allergies (among others). Lungs are described as clear with no wheezes, rales, rhonchi, or signs of consolidation by Dr. Blackwell.

-Radiology report dated May 18, 2002 by Dr. John McMurray: several enlarged nodes (3cm x 2cm right paratracheal enlarged node are seen; another enlarged node seen in the precarinal location; one measuring 4cm was seen in the subcarinal location); mass measuring 7cm x 5cm in the right infrahilar region; left lung is expanded and clear.

-Pulmonary consultation report by Dr. Bruce Grover dated May 20, 2002. History of coal mine employment is noted, as well as coronary disease status post coronary bypass surgery. Smoking history notes Miner quit in 1991. A lung mass is seen in an x-ray and a CT scan, but is not identified at this point. Chest is described as having some erythema at the umbilicus with no wheezing and a symmetric percussion. Ultimate impressions include: right lung mass with hilar and mediastinal adenopathy suspicious for bronchogenic carcinoma to chest pain probably related to the lung mass, cardiac ischemia, renal insufficiency with creatinine.

-Cytopathology Report by Dr. Van Buren (with concurrence by Dr. Gary Adelson) dated May 21, 2002: slide preparations taken from subcarinal mass in Miner's right lung reveals poorly differentiated large cell carcinoma.

-Hematology/oncology consultation report by Dr. Edwin McElroy dated May 22, 2002. Social history considers tobacco use and coal mine work. Miner only complains of migratory chest discomfort. Miner appears to be in no acute distress. His chest is noted as being clear to auscultation bilaterally with a prolonged expiratory phase. Impressions include at least a Stage III-b nonsmall cell lung cancer.

-Radiation-oncology consultation report by Dr. Brooks Talton dated May 23, 2002: verbal report that the right upper lung mass represents non-small cell carcinoma and CT reveals multiple enlarged mediastinal and paratracheal lymph nodes with a large subcarinal mass. The mass is 7x5cm and located in the right infrahilar region impinging on the mediastinum. Combined therapy is recommended.

-Discharge Summary dated May 23, 2002: diagnoses include lung cancer – poorly differentiated large cell carcinoma of the lung, chest pain, and coronary disease, status post coronary artery bypass surgery.

Pulmonary Associates of Kingsport
-Consultation report dated June 6, 1997 with Dr. Larry Foster: history of pneumoconiosis is noted; mother died of asthma at age thirty-eight; stopped smoking in 1991 with a 100 pack day habit; x-ray shows limited expansion bilaterally with an ill-defined pleural based shadow in the left upper lung zone – markings are slightly increased bilaterally in both lungs; CT scan shows no significant adenopathy and a "very small ill-defined nodule in the right upper lung zone of unclear significance." No other abnormalities are noted on the CT.

Southwest Virginia Regional Cancer Center
-Office note dated May 30, 2002 from Dr. David Miller: Assessment includes stage III-B nonsmall cell carcinoma of the lung originating from the right infrahilar region with multiple mediastinal lymph node involvement and allergies. Chemotherapy is to begin on June 5, 2002 and continue on a weekly basis.

-Office note dated June 17, 2002: history of present illnesses/diagnoses include: nonsmall cell carcinoma felt to be at least Stage III-B; CT of thorax showed 3x2 cm right peritracheal enlarged lymph node with a mass subcarinal location 4 cm in size and an area of consolidation or mass 7x5 cm in size extending from the right infrahilar lesion. Bronchoscopy by Dr. Bruce Grover with biopsy shows poorly differentiated large cell carcinoma from fine needle aspiration of subcarinal mass. Assessment is stage III-B nonsmall cell lung carcinoma.

Death Certificate

The death certificate states Miner passed away on August 1, 2002 at 11:00am. (DX 13). Congestive heart failure and lung cancer are listed as the causes of death. Under business/industry, Miner is noted to be a coal miner. The certificate is signed by the coroner, Delbert Anderson. It notes no autopsy was performed.

Smoking History

There are only two sources in the record regarding Miner's smoking history. First, Claimant testified through deposition that the treatment records were incorrect, and that Miner stopped smoking in 1988/89 and that he smoked less than half a pack a day. (DX 9). Second, we have numerous treatment records which indicate Miner smoked sixty years at a rate of two packs a day. (DX 11, 20, 21). I find the treatment records to be more persuasive here. First, the only source the physician could have would have been the Miner himself. Second, a family member is much more likely to downplay Miner's smoking history. As such, I find Miner smoked two packs a day for sixty years, or 120 pack years.

DISCUSSION AND APPLICABLE LAW

Claimant filed her survivor's claim on September 26, 2005. (DX 2). Entitlement to benefits must be established under the regulatory criteria at Part 718. *See Neeley v. Director, OWCP*, 11 B.L.R. 1-85 (1988). The Act provides that benefits are provided to eligible survivors of a miner whose death was due to pneumoconiosis. § 718.205(a). In order to receive benefits, the claimant must prove that:

1). The miner had pneumoconiosis;

2). The miner's pneumoconiosis arose out of coal mine employment; and

3). The miner's death was due to pneumoconiosis.

§§ 718.205(a). Failure to establish any of these elements by a preponderance of the evidence precludes entitlement. *See Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26, 1-27 (1987).

Pneumoconiosis

Collateral estoppel at its essence refers to the effect of a judgment in foreclosing re-litigation in a subsequent action of an issue of fact that has actually been litigated and determined in the initial action. *Freeman v. United Coal Mining Co. v. Director, OWCP [Forsythe]*, 20 F.3d 289, 18 BLR 2-189 (7th Cir. 1994). In order to invoke collateral estoppel, Claimant must establish that:

1. The precise issue raised in the present case must have been raised and actually litigated in the prior proceeding;

2. The determination of the issue must have been necessary to the outcome of the prior proceeding;

3. The prior proceeding must have resulted in a final judgment on the merits; and

4. The party against whom estoppel is sought must have had a full and fair opportunity to litigate the issue in the prior proceeding.

N.A.A.C.P., Detroit Branch v. Detroit Police Officers Ass'n, 821 F.2d 338 (6th Cir. 1987); *Collins v. Pond Creek Mining Co*., 22 BLR 1-229 (2003); *Hughes v. Clinchfield Coal Co*., 21 BLR 1-134 (1999)(*en banc*).

In the case where Miner was awarded benefits on August 27, 1987 by Judge Pierce, the issue of whether Miner suffered from pneumoconiosis was both raised and litigated. (DX 1-32). Therefore, the first element is met. The ultimate determination in the case was total disability due to pneumoconiosis under the Act. (DX 1-37). As the establishment of pneumoconiosis is required before a finding of total disability due to pneumoconiosis can be rendered, it is a necessary component to the outcome of the proceeding. *See* Section 718.202(d)(1-3). Therefore, the second element is met. Judgment was rendered on the case on August 27, 1987 with an affirmation issued by the Benefits Review Board on July 27, 1989. (DX 1-7). This judgment was entered after the merits of both parties were considered. As the proceeding resulted in a final judgment on the merits, the third element is met. As Employer had a full and fair opportunity in which to litigate the issue in the prior proceeding, the final element is met and collateral estoppel should apply.

Also, in *Collins v. Pond Creek Mining Co.*, 22 BLR 1-229 (2003), the Board held that an employer is collaterally estopped from re-litigating the issue of whether pneumoconiosis is present if (1) there is a prior decision awarding benefits in a miner's claim, and (2) no autopsy is performed in the survivor's claim.[22] Here, we have a decision awarding benefits in Miner's claim with no autopsy evidence submitted in the present case. (DX 1-32). Thus, collateral estoppel applies in the instant case. Therefore, Claimant has established the existence of pneumoconiosis.

Arising out of Coal Mine Employment

In order to be eligible for benefits under the Act, Claimant must prove that Miner's pneumoconiosis arose, at least in part, out of his coal mine employment. § 718.203(a). For a miner who suffers from pneumoconiosis and was employed for ten or more years in one or more coal mines, it is presumed that his pneumoconiosis arose out of his coal mine employment. *Id.* As I have found that Claimant has established thirty-two years of coal mine employment, I find that Claimant is entitled to the rebuttable presumption as outlined in § 718.203(b). Employer has put forth no medical opinions that state Miner's pneumoconiosis did not arise out of coal mine employment. Therefore, Claimant has established this element of entitlement.[23]

Death Due to Pneumoconiosis

Having established that Miner suffered from pneumoconiosis arising out of coal mine employment, Claimant is now required to prove that Miner's death was due to pneumoconiosis in order to be entitled to benefits. Subsection 718.205(c) applies to survivor's claims filed on or after January 1, 1982 and provides that an eligible survivor will be entitled to benefits if any of the following criteria are met:

1. Where competent medical evidence establishes that pneumoconiosis was the cause of the Miner's death, or

2. Where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or where death was caused by complications of pneumoconiosis, or

3. Where the presumption set forth in § 718.304 (evidence of complicated pneumoconiosis) is applicable.

20 C.F.R. § 718.205(c).

Pneumoconiosis is a "substantially contributing cause" of a miner's death if it hastens the miner's death. § 718.205(c)(5). The presumption set forth in § 718.304 is not applicable because Claimant has not established the presence of complicated pneumoconiosis. Therefore,

[22] An exception to this is when 4th Circuit Law under *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000) applies. As this case arises under the 6th Circuit, *Island Creek* is inapplicable.

[23] I also note that even if a reviewing board disagreed with this analysis, this element would also be established through the application of collateral estoppel, as outlined *supra*.

in order for Claimant to be entitled to benefits, she must show that pneumoconiosis was the direct cause of Miner's death or that pneumoconiosis hastened Miner's death.

A death certificate, in and of itself, is an unreliable report of the miner's condition and it is error for an administrative law judge to accept conclusions contained in such a certificate where the record provides no indication that the individual signing the death certificate possessed any relevant qualifications or personal knowledge of the miner from which to assess the cause of death. *Smith v. Camco Mining, Inc.*. 13 B.L.R. 1-17 (1989); *Addison v. Director, OWCP*, 11 B.L.R. 1-68 (1988). Here, this is the case. There is no indication that Mr. Delbert Anderson possessed any firsthand knowledge as to the causes of death. Therefore, the conclusion stated on the death certificate shall carry little weight.

The reports of Drs. Clarke and Nash were written in 1983 – nearly twenty years before Miner passed away. (CX 3, 4). It would be impossible for either physician, at this point in time, to offer an opinion as to the cause of Miner's death. Therefore, I accord these opinions no weight in determining if pneumoconiosis caused or contributed to Miner's death.

The medical records, which are outlined in great detail above, make only one reference to pneumoconiosis under the "history section" of Dr. Foster's 1997 consultation report. A few references are also made under the treatment records of a mild COPD. However, none of these medical records specifically connect the finding of COPD to coal dust exposure, and not one physician seems to opine in any way that this condition hastened the Miner's death. The records simply paint a picture of Miner's slow decline – without mentioning pneumoconiosis.

Drs. Jarboe and Castle, who are both board certified in internal and pulmonary medicine, as well as a B-readers, opine that pneumoconiosis played no role in causing, or contributing to, Miner's death. Even though each physician is of the opinion that Miner did not suffer from pneumoconiosis, I find this to not diminish the weight of their opinion regarding his death.[24] Both specifically point to the fact that PFT testing done at the time Miner was first diagnosed with lung cancer provided normal results, demonstrating a normal lung function. They also comment on how the treating physicians at the hospital find the breathing capacity to be normal on physical examination. Both also state that from that point – the steady decline in Miner's pulmonary capacity can easily be attributed to the chemotherapy and radiation treatment he received in conjunction with Miner's obesity and cardiac health. Furthermore, they note Miner also has a documented history of severe allergies and asthma. Through their depositions, Drs. Jarboe and Castle both walk through the steady decline in Miner's heath as seen in the treatment records, and how each step in decline is attributable to Miner's growing lung cancer – which ultimately resulted in his death. Even though it did not receive much weight, the death certificate confirms this. Given Drs. Jarboe and Castle's strong credentials, combined with their detailed analysis of the record and how it led them to conclude pneumoconiosis played no role in causing or contributing to Miner's death – I find their opinions to be well reasoned and well documented. As such, I accord each opinion probative weight.

[24] Dr. Jarboe stated that even if he considered that Miner had pneumoconiosis – it would not change his opinion as the medical evidence paints a clear picture of a man who died from lung cancer. *See Supra*.

Given that no reasoned opinion exists to contradict the conclusions of Drs. Jarboe and Castle, I find that Claimant has failed to prove that Miner's pneumoconiosis either caused or contributed to Miner's death.

Therefore, I find that Claimant has not established that Miner's death was hastened by his totally disabling pneumoconiosis arising out of coal mine employment under Section 718.205(c).

Entitlement

While Claimant proved the existence of pneumoconiosis, Claimant has failed to prove by a preponderance of the evidence that Miner's death was due to or hastened by pneumoconiosis. Therefore, I find that Claimant is not entitled to benefits under the Act.

Attorney's Fees

An award of attorney's fees is permitted only in cases in which the claimant is found to be entitled to benefits under the Act. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for the representation and services rendered in pursuit of the claim.

ORDER

IT IS ORDERED that the claim of C.R. for benefits under the Act is hereby DENIED.

A

THOMAS F. PHALEN, JR.
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).